State of Illinois
Department of Children and Family Services

SIBLING VISITATION FORM

Date _____

Name of FP Hosting Visit _____ Name of Sending FP _____

Address _____ Address _____

_____ _____

Phone (___) ___ - _____ Zip _____ Phone (___) ___ - _____ Zip _____

FP License Number _____ FP License Number _____

How many children are there in the sibling group? _____

Child(ren) Name(s)	ID Number	Sex	Age	Date of Visit

Worker's Name	Regional Office	Phone	Supervisor	Supervisor's Phone
		( ) -		( ) -
		( ) -		( ) -
		( ) -		( ) -
		( ) -		( ) -
		( ) -		( ) -
		( ) -		( ) -

Did worker give permission and/or assistance with planning the visit? ☐ Yes ☐ No
If no, please give reason/comments: _____

_____

How long was the visit? (i.e., daytime, overnight, weekend) _____

Who transported the child(ren)? _____

_____

What activities did the child(ren) participate in? _____

_____

Medical Problems

Was medical card sent with the child(ren)? Yes ☐ No ☐
Did child(ren) require medication? Yes ☐ No ☐
Was medication brought with child(ren)? Yes ☐ No ☐

If not, reason: _____

Name of medication: _____

How did the child(ren) interact with each other? _____

_____

_____

Foster Parent Signature _____ Date _____

DCFS Worker/Supervisor Signature _____ Date _____

CFS 315
10/90